

Full Name: _____ Date of Birth: ____ / ____ / ____

Lifestyle

- Exercise: No Yes (Type/Frequency: _____)
- Illicit Drugs: No Yes (Type/Frequency: _____)
- Tobacco: No Yes (Type/Frequency: _____)
- Alcohol: No Yes (Type/Frequency: _____)
- Caffeine: No Yes (Type/Frequency: _____)

Current Medications

If you have a separate list, please provide a copy to your provider and note "SEE LIST".

Allergies

Please list all known allergies, including medications, food, environmental, etc.

Medical History

Check all that apply.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke (TIA/"Mini") |

Surgical History

Check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Tonsils Removed |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Gallbladder |

Additional Information: _____

Family Medical History

Check all that apply and/or fill in the blanks as appropriate.

Mother: Living Unknown Deceased (Age/Cause: _____)

Father: Living Unknown Deceased (Age/Cause: _____)

Condition	Maternal ✓	Paternal ✓	Type/Details
Cancer			
Heart Attack(s)			
Open Heart Surgery			
Thyroid Disease			
Depression			
High Blood Pressure			
Psychiatric Disorders			
Diabetes			
High Cholesterol			
Stroke(s)			

Siblings: # Living _____ # Deceased _____

Please describe sibling(s)'s known medical conditions: _____

Diagnostic/Health Maintenance

Have you previously had a bone density scan (DEXA)? No Yes

If YES, when & where was your most recent scan? _____

COMPLETED BY:

 Signature Name (Printed) Date